The Mental Health Consequences of Torture

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Introduction

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This book is a review of the scientific evidence about the mental health consequences of torture and related violence and trauma. As a broadly focused review, the book addresses such topics as the short- and long-term psychological, neurobiological, social, economic, and disability-related consequences of such trauma; models for studying these consequences; treatment and rehabilitation for survivors; and models for delivering mental health services. Research information related to public policy, legal issues, and caregiving is included. The perspective of the survivor of torture has been an integral part in the development of the information included throughout this book.

The key question addressed is how the experience of intentional psychological and physical torture affects individuals, families, and societies. Individual torture, large-scale massacres, religious or ethnic cleansings, death squads, the disappearance of loved ones, and random war-related violence can all have profound and enduring effects on the physical and mental health of people. The nature of these effects is addressed in this book through a review of relevant scientific information and a discussion of related policy, legal, and personal issues.

MENTAL HEALTH CONSEQUENCES OF VIOLENCE AND TRAUMATIC STRESS

A major problem of our time is the destructive role of violence and traumatic stress in the lives of millions of people throughout the world. Estimating the

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numbers (prevalence and incidence) of victims of violence and traumatic stress is a challenge, in large part because of the variations in the nature and definitions of these problems. Many life situations contribute to the scope of victimization, including poverty, political oppression, ethnopolitical warfare, torture, mass violence, violent crime, and family abuse, all of which occur without respect to geographical boundaries, social class, race, gender, or age. Because of the widespread and ongoing nature of such exposure, the consequences for people will continue to be a worldwide concern. Generally, the focus of research and treatment of those exposed to such violence and trauma is on individuals, but these kinds of experiences also affect the health and well-being of families, communities, societies, and entire nations. The legacy of these experiences often continues into subsequent generations, creating an enduring cycle of pain and suffering. Because of these widespread, profound, and enduring experiences, the prevalence of trauma-related disorders and disabilities may well exceed that of any other psychiatric disorder (de Girolamo & MacFarlane, 1996). Among the most enduring are the effects of torture.

BACKGROUND

In response to concerns regarding the mental health consequences of torture and related violence and trauma, especially among survivors of torture residing in the United States, the National Institute of Mental Health (NIMH), in collaboration with the Center for Mental Health Services, the Office of Refugee Resettlement, and Senator Paul Wellstone (D-Minnesota), sponsored an international conference on April 10–11, 1997, in Washington, D.C., to discuss mental health research and services for torture and trauma survivors. This conference, Survivors of Torture: Improving Our Understanding—A National Conference on Mental Health Research and Services for Refugees and Asylum-Seekers in the United States Who Are Survivors of Torture, brought together the representatives and converging interests of more than 100 research and service organizations, national and international agencies, human rights and advocacy groups, and survivors of torture. The participants included representatives of South Africa, who met with Steven E. Hyman, the Director of NIMH, and asked for help in compiling scientific information on the mental health consequences of torture. These participants felt such information would be a major contribution to South Africa and to the entire world, with a particular urgency for information about the psychological needs of the increasing number of torture and trauma survivors. In response to this request, NIMH established the Working Group on the Mental Health Consequences of Torture and Related Violence and Trauma. This panel, which was staffed with 24 international trauma and torture research experts, resulted in a report to the South Africa Truth and Reconciliation Committee and this book.

CONCEPTUAL AND DEFINITIONAL CONCERNS

To provide a foundation for this discussion of the mental health consequences of torture, a review of conceptual and methodological issues that permeate research and clinical practice may be helpful.

Focus on Torture

One fundamental question is why the primary focus for this book is on the torture experience itself, rather than on a general discussion of other forms of organized, interpersonal, or mass violence? As noted by several of the contributors to this volume, a reasonable argument could be made that the focus should be on the wider population of persons (survivors and perpetrators) who experience mass violence, other forms of severe trauma, stress in war, and other forms of social upheaval. However, ultimately, the focus on the mental health consequences of torture is inherently important for several reasons. Torture is one of the most extreme forms of human violence, and the consequences of torture represent a critically understudied area of scientific research. Because of the extreme and horrific nature of the torture experience, an understanding of how it affects human beings can contribute to better psychological and medical treatment and to overall improvements in the delivery of services to survivors. As a human action, torture horrifies and evokes a strong reaction among the public, governments, and policymakers. But it is the survivors themselves who can speak most directly to this experience, providing essential insights regarding necessary changes in policy and health care. While studies of other forms of trauma and violence have a great deal to offer an investigation of the effects of torture, the defining and unique characteristics of torture itself make the study of its effects one that enlarges and improves the field of trauma research.

Researchers and clinicians have begun to recognize that the destructive medical and psychological consequences associated with the experience of "torture and related violence and trauma" often extend beyond the survivor to include family members, the perpetrator, the treatment provider, and society (Basoglu, 1992; Kinzie & Boehnlein, 1993; McCann & Pearlman, 1990; Nightingale, 1990). In many instances, an individual may have multiple roles—refugee, survivor of torture, perpetrator of violence—and thus may have numerous and complex needs. It is not uncommon in contemporary civil wars for civilians to occupy such multiple roles concurrently or to move between the roles of combatant, victim, and survivor before, during, or after periods of victimization, persecution, and displacement. This complexity notwithstanding, the focus of this book is on survivors of torture and related trauma and not on perpetrators per se, with the recognition that the complex relationship between perpetrators and victims of human rights violations is also worthy of a full review.

Definitions: Torture and Related Violence and Trauma

Because of scientific, political, and national health policy concerns, a continuing debate is under way to examine the elements of a precise definition of torture. Specific issues are outlined below, but a number of relevant publications also address this controversial question (e.g., Basoglu, 1992; Jaranson, 1998; Marsella, Bornemann, Ekblad, & Orley, 1995; National Immigration Law Center, 1994).

Torture

The term "torture" has been defined in different ways by different organizations for different purposes. According to Jaranson (1995, 1998), the two most commonly used definitions of torture have been formulated by the World Medical Association and the United Nations. The World Medical Association's definition, frequently called the Declaration of Tokyo, was developed in 1975 and has been widely accepted among the medical community, where it governs professional standards and ethics. The Declaration of Tokyo defines torture as "the deliberate, systematic, or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason" (Amnesty International, 1985, pp. 9–10).

Alternatively, the definition of torture developed by the United Nations delineates the legal and political responsibilities of governments (Jaranson, 1995, 1998):

> For the purpose of this convention, the term "torture" means any act by which pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person, information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions (United Nations, 1989, p. 17).

Jaranson (1998) describes the World Medical Association's version as the broader definition, one that does not require the perpetrator to be affiliated with a government or to act officially with governmental approval. Consequently, the actions described could be interpreted to include torture as part of domestic or ritualistic abuse as well as part of criminal activities. Conversely, the United Nations' definition limits torture to those acts perpetrated, directly or indirectly, by those in "an official capacity" and appears to exclude three groups: (a) torture perpetrated by unofficial rebels or terrorists who ignore national or international mandates, (b) random violence during war, and (c) punishment allowed by national laws, even if the punishment uses techniques similar to those of torturers. Jaranson concludes that some professionals in the torture rehabilitation field consider the United Nations' definition to be too restrictive and favor a definition of politically motivated torture that is broad enough to include all acts of "organized violence" (van Willigen, 1992).

In general usage, the term "torture" describes a situation of horrific pain and suffering being inflicted on someone, often in captivity. Torture, despite variations in cultural manifestations, is cruel and degrading abuse of human beings with the potential for serious lifelong suffering.

Throughout this volume, various legal or statutory definitions are used. However, it is also recognized that, for the purposes of this volume, the experience of torture may extend beyond statutory or legal definitions to include other characteristics, as documented in personal testimony or in clinical or medical settings.

Violence

Webster's II New Riverside University Dictionary (1995) defines violence as "physical force employed so as to violate, damage, or abuse; an act or instance of violent behavior or action; abusive or unjust use of power." In scientific, clinical, or general usage, the term "violence" has many definitions and applications. In this volume, the term "violence" refers to individual and group experiences (e.g., ethnopolitical warfare, crime, family abuse, political oppression, and torture) that combine the concepts of deliberate and wrongful use of force with the intention of violating, damaging, or abusing another.

Trauma

The term "trauma" has both a medical and a psychiatric definition. Medically, trauma refers to a serious or critical "bodily injury, wound, or shock" (Neufeldt, 1988). This definition is often associated with trauma medicine practiced in emergency rooms and is also a generally accepted layperson view of the term. However, in psychological terms, and in this volume, trauma assumes a different meaning, referring to a "painful emotional experience, or shock, often producing a lasting psychic effect" (Neufeldt, 1988).

Psychiatric Symptoms and Disability

The psychiatric definition of trauma has become inherently associated with the diagnosis of posttraumatic stress disorder (PTSD). PTSD is a formally recognized psychiatric disorder. According to the American Psychiatric Association, PTSD can result from "exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death, injury, experienced by a family member or other close associate" (American Psychiatric Association, 1994, p. 424).

The diagnosis of PTSD varies according to onset patterns, including acute (symptoms last less than 3 months), chronic (symptoms last 3 months or longer), and delayed (at least 6 months pass between the traumatic event and the appearance of symptoms) onset patterns (American Psychiatric Association, 1994). For

PTSD to be diagnosed, the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994) requires a particular combination of symptoms, including some relating to a reexperiencing of the traumatic event, persistent avoidance of stimuli associated with the event, persistent symptoms of increased arousal, symptom duration of greater than 1 month, and significant clinical distress or impairment in various areas of functioning.

Most groups, including survivors of torture, mental health researchers, and therapists, agree that the PTSD diagnosis can be a useful tool for describing the suffering and symptoms of survivors of torture and trauma, for gauging the extent and severity of traumatic experiences, and for planning and delivering clinical interventions. At the same time, these experts generally agree that the PTSD diagnosis alone is wholly inadequate to describe what it means to be a survivor of such trauma. As noted in the next chapter of this book by Ortiz, "The consequences of torture are multidimensional and interconnected; no part of the survivor's life is untouched." And as a survivor recounted at the April 1997 NIMH conference, "We struggle to make sense of what happened to us, to our community, and to our world. We are survivors who struggle to reclaim our dignity and our trust in humanity and in ourselves."

Researchers and clinicians have also proposed a number of other trauma-related clinical syndromes, including survivor syndrome, torture syndrome, prisoner of war syndrome, concentration camp syndrome, vicarious traumatization syndrome, and gross stress reaction syndrome. Although these syndromes are not recognized as medical diagnoses in either the *International Classification of Diseases and Related Health Problems* (10th revision) (World Health Organization, 1992) or DSM-IV, they have often proven to be useful within clinical settings where therapists and other professionals strive to understand the broad spectrum of symptoms and disabilities associated with torture experiences.

ORGANIZATION OF THE BOOK

Torture is a horror designed by human beings, one that is difficult to describe or understand. The role of survivors is crucial in bridging the gap of communication and understanding between survivors and those who have not directly experienced torture, particularly those designated as their caregivers. For this reason, in chapter 2 the perspective of the survivor is introduced, and it is integrated throughout the book. The survivor perspective challenges researchers, clinicians, and others working with survivors of torture to carefully consider the changes in the world of the survivor, the many meanings of mental health and medical diagnoses, the sources of ongoing stress, the role of faith and support, and the purposes of therapy. The experiences of survivors provide a window to this unique perspective. The survivor perspective also highlights the extraordinary ability of some individuals to manage and function with strength and courage in the wake of almost unimaginable experiences.

While most of this book is a review of the empirical literature on a number of relevant topics, chapter 3 reviews the mental health research work that focuses directly on survivors of torture. Research has been conducted on the scope and effect of torture and the role of risk and protective factors. Outcome studies have focused on a variety of measures, including PTSD; other psychological disorders and outcomes; neurobiological findings; cognitive outcomes; physical health; and economic, disability, and social consequences. Recommendations for future research are included in this section and throughout the book.

Next, for readers who are less familiar with psychological research in the area of trauma, three approaches for conceptualizing the consequences of torture and related violence and trauma are reviewed. Psychosocial, neurobiological, and economic models for examining the etiology, course, treatment, and prevention of the consequences of traumatic stress, including torture and related violence and trauma, are discussed. First, chapter 4 outlines some of the major psychological and psychosocial models that have been used to examine and conceptually understand the consequences of traumatic stress. For example, because of the inherent relationship between trauma and torture, PTSD has emerged as the most frequently studied disorder associated with torture (Basoglu, 1992). However, other researchers have pointed out that responses to torture and trauma can include a broad spectrum of disorders, including depression, psychosis, anger and rage, paranoia, sleep disorders, substance abuse, anxiety, and dissociative disorders (e.g., Marsella, Friedman, Gerrity, & Scurfield, 1996; Turner & Gorst-Unsworth, 1993). In addition to these disorders, survivors may also experience hopelessness and existential despair in the aftermath of torture as they seek to construct some sort of meaning and coherence from this gross violation of their being. The Italian writer, Primo Levi, a survivor of the torture of the Nazi concentration camps, wrote, "The purpose of existence itself is challenged by the fact of torture" (Levi, 1979).

Next, chapter 5 briefly reviews the literature concerning trauma-related neurobiological research and presents several useful models coming from animal and human studies. Recently, medical researchers have identified a range of neurophysiological disorders associated with traumatic stress, including disorders of the hypothalamic–pituitary–adrenal axis, the prefrontal dopaminergic system, the locus coeruleus noradrenergic system, and the thyroid gland and hippocampus (Grillon, Southwick, & Charney, 1996).

Chapter 6 on economic models discusses the health effects of torture from the perspective of the cost to society and the economic burden of disease, disorder, and disability. Recently, many mental health-related scientific disciplines have been recognizing that the value and success of research and interventions targeting mental disorder and illness need to be judged not only on their ability to reduce and prevent symptoms of such conditions, but also on their ability to explain the relationship between disorder, disability, and functioning. This chapter briefly reviews current literature on individual and societal disability, including the economic effects of trauma. While it is unusual in psychological literature to discuss life and health in economic terms, this perspective is inherently valuable in developing comprehensive and humane public health policy.

The next major sections of this book review several relevant bodies of literature on violence and trauma (chapters 7 to 15). Relevance was judged based on the extent to which a research area focused on traumatic experiences that can involve similar patterns of exposure, psychobiological responses, or therapeutic treatments. The research topics or groups reviewed in these chapters are as follows: refugees and asylum-seekers; veterans of armed conflicts; former prisoners of war; and victims of Holocaust trauma, rape and sexual assault, homicide and physical assault, war-related trauma, domestic violence, and child trauma. Included is a review of the scientific literature related to exposure, effects, risk, and protective factors, and recommendations for future research.

A discussion of the complex and challenging assessment and intervention issues follows in chapter 16. Examining successful interventions at various levels (e.g., individual, communal, and societal) for survivors of other traumatic experiences has the potential to benefit torture survivors who are also at risk of developing a range of psychobiological, emotional, behavioral, and social difficulties following the torture experience. Measurement issues are discussed in chapter 17, emphasizing the numerous procedural and psychometric challenges in this area of study. This chapter gives a brief discussion of current instruments and approaches and ethical considerations for research and treatment.

Services for survivors of torture are delivered by many different kinds of providers in many different settings throughout the world. Chapter 18 focuses on mental health services delivery models relevant to the treatment of survivors of torture. By addressing the structure or organization of systems of care, including access, process, and outcomes, the material in this chapter explores ways in which existing systems can be made more sensitive and effective in providing mental health care for survivors of torture. Survivors of torture can be from many countries and are found in many different health care situations (e.g., as refugees in a new country, as individuals who stay in their home countries, or as individuals tortured in a foreign country who then return to a home country). Although it is impossible to describe a single system that would be responsive and practical in all situations, the general field of mental health services research has struggled with many similar issues, and relevant research findings are presented here.

The role of professional caregivers and the relationship between the caregiver and the survivor are important to the process of healing. Chapter 19 presents research and clinical findings and addresses the complex challenges of providing care when caregivers are confronted each day with often horrific human experiences, as well as the difficulties of developing appropriate treatment with limited resources.

How public policy and the law can influence the lives of survivors and those who care for them is reviewed in chapter 20, which presents research findings regarding public policy and legal approaches to addressing the needs of survivors, with a particular emphasis on the role of reparation and restorative justice for survivors.

Finally, chapter 21 summarizes selected research findings reported in this book to point to future directions for further work.

This book was developed in the spirit of collaboration and cooperation among survivors, clinicians, researchers, and policymakers in an effort to make scientific and other critical information more readily available to those who undertake to solve this complex and disturbing problem throughout the world.

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